SPECIAL SERVICES PRIOR AUTHORIZATION – REQUEST/AUTHORIZATION FORM

This form is provided in PDF format to be used by Medical/DME Supplier, Orthotic and Prosthetic Providers, Speech Type 80 Providers, and Hearing Aid Dealers.

Once filled out this form m ay be faxed to:

(517) 335-0075

Please provide a copy of the medical documentation, which supports the requested services, including current doctor’ s script.

SPECIAL SERVICES
PRIOR APPROVAL - REQUEST/AUTHORIZATION
Michigan Department of Community Health

1. Control Number

NOTE: APPROVAL REFERS TO SERVICE AND DOES NOT GUARANTEE RECIPIENT ELIGIBILITY.

CONSULTANT USE ONLY

2. | 3. | 4. | 5. | 6. | 7. | 8. | 9. | 10.

11. Prior Authorization No.

12. Provider's Name *(Last, First, Middle Initial)*	13. Type	14. ID Number	15. Provider Use Only
16. Provider's Address *(Number, Street, City, State, Zip)*			17. Phone Number
18. Recipient's Name *(Last, First, Middle Initial)*	19. Sex	20. ID Number	21. Birth Date / 22. County
23. Recipient's Address *(Number, Street, City, State, Zip)*			24. Does Patient Reside in a Nursing Care Facility ☐ YES ☐ NO
25. Referring Physician's Name *(Last, First, Middle Initial)*	26. Type	27. ID Number	28. Phone Number
29. Referring Physician's Address *(Number, Street, City, State, Zip)*			

30. Line No.	31. DESCRIPTION OF SERVICE (Include brand name and model number where applicable)	32. Procedure Code	33. Quantity	34. Charge	35. Modifier
01					
02					
03					
04					
05					

36. Primary Diagnosis Description and Prescription (Quote Physician Order)	37. Remarks and/or Documentation of Medical Necessity

38. Indicate Any Other Services Provided To This Recipient During the Past Year

39. PROVIDER CERTIFICATION: The patient named above (parent if minor or authorized representative) understands the necessity to request prior approval for the services indicated in item 31. I understand the services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State Law.

Provider Signature _____ Date _____

CONSULTANT USE ONLY

40.	41.	42.
APPROVED AS:	DISAPPROVED ☐	
PRESENTED ☐	NO ACTION ☐	
AMENDED ☐	INSUFF. DATA ☐	
		Consultant Signature _____ Date _____

MSA-1653-B (Rev. 4-96) Previous edition may be used.

MAIL TO MDCH